

CHECKLIST FOR LATENT TUBERCULOSIS INFECTION TREATMENT

Practitioner Name: _____

Patient Name: _____

Please check the appropriate boxes.

- ☐ 1. This patient had a positive skin test. Date test measured: ____/____/____

Result of test: (Please check one)

☐ 15 mm induration

☐ 10 mm induration and the patient has some risk factors for TB. (e.g. recent arrival to U.S., resident or employee of congregate settings such as healthcare workers, child < 4 years)

☐ 5 mm induration and the patient is immunosuppressed, HIV-infected, a contact to an active case of TB, or shows radiographic evidence of previous TB infection.

Was the patient vaccinated with BCG in his/her country of origin?

☐ No ☐ Yes Date of vaccination: ____/____/____

- ☐ 2. The patient has **NO** signs or symptoms, or radiographic evidence of active TB.

Date of chest x-ray: ____/____/____

- ☐ 3. The patient is willing and able to complete a full course of therapy.

- ☐ 4. The patient will be available for clinical monitoring during the full course of treatment.

- ☐ 5. The patient has **NO** medical contraindications to treatment. (e.g. severe liver disease or drug sensitivity)

- ☐ 6. The proper label will be attached to the medication.

- ☐ 7. The patient has been counseled about drug interactions and side effects.

- ☐ 8. The practitioner will dispense the medication incident to practice.

Practitioner signature

Date